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2240.10.00 **RESPONSIBILITY OF INITIATING COUNTY**
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2240.15.05 Receiving County Responsibilities (I)

2240.20.00 **TRANSMITTAL OF HARD COPY CASE RECORD**

2240.30.00 **INTERSTATE TRANSFER CASES (C, I)**

2299.00.00 **FOOTNOTES FOR CHAPTER 2200**

2200.00.00 CONTINUING CASE PROCESSING

This chapter contains policy regarding continuing case processing, including:

Continuing Case Processing (Section 2200)

Redeterminations (Section 2205)

Processing Redeterminations (Section 2210)

Changes (Section 2215)

Processing Changes (Section 2220)

Adding An Individual To The AG (Section 2225)

Acting On Changes Between Redeterminations (Section 2230)

Timely Notice Of Adverse Action (Section 2235)

AG Changes Address (Section 2240)

Footnotes for Chapter 2200 (Section 2299)

2205.00.00 REDETERMINATIONS (F, C, MED)

Periodic reviews of eligibility must be made on assistance cases to ensure that benefits are computed correctly. The requirements for redeterminations are discussed in this section.

A redetermination is the process in which the caseworker gathers information on the circumstances of the case members and verifies all changeable elements to establish continuing eligibility.

In general, during a redetermination the following must occur:

The individual or authorized representative participates in an interview;

a new CAF containing current information is printed and signed by the individual or authorized representative; and

all changeable eligibility factors for the AG are verified.

2205.05.00 ESTABLISHING THE REDETERMINATION MONTH

The redetermination month is the month during which eligibility for all assistance groups in a case is reinvestigated. Federal regulations define the maximum time frames for completion of redeterminations for each program. If there are multiple AGs in the case, the redetermination month is established at the earliest required interval based on the following requirements:

Food Stamp AGs which contain all elderly or disabled members will be assigned a 12 month redetermination. All other Food Stamp AGs will be assigned a 6-month redetermination.

Alignment of certification periods is necessary with another TANF, Medicaid or FS AG at the same address.

If there is a need to assign a shorter certification period, this is done by merely rolling back the date on AEWAA before authorization of an application, reapplication or redetermination.

TANF AGs will be assigned 6 month redetermination periods.

When adding a new FS AG to a case during a recertification of an existing FS AG, the system will align both certification periods so they will end at the same time. This is true for a 6-month certification.

EXAMPLE: The worker is doing a redetermination on 6-2-01 effective 7-1-01 for FS/01 which is a 12 month certification. FS/02 is being added to the case during the redetermination and this certification will also be for 12 months. ICES will correctly give FS/01 an 11 month certification beginning 7-1-01 and ending 5-31-02 since FS/01 will start 6/2/01 and also end 5-31-02.

For TANF, a redetermination must be completed at least once every six months. (f1)

For Medicaid, a redetermination must be completed at least once every 12 months. Note that special provisions exist for recipients in the Newborn (MA X) and Transitional Medical Assistance (TMA) categories. An MA X recipient is entitled to 12 months of Medicaid as long as he lives with his mother, and cannot be subjected to redetermination requirements prior to the end of the 12-month period. An MA F recipient is subject to periodic reporting requirements as discussed in Section 3800. (f2)

2205.10.00 SCHEDULING REDETERMINATION INTERVIEWS

Food Stamp AGs are notified via a notice of expiration of its certification period 45 days prior to the expiration date or the Friday before if the 45th day falls on a weekend. The AG is expected to file a new application prior to the 15th of the last month of the certification period. This would be considered a timely redetermination. AG applications made after the 15th of the last month of the certification period are an untimely application for benefits.

Redetermination lists are available on IQRE using the caseload number in the parms. Redeterminations for a particular month can be obtained by entering the caseload number/ccyymm in parms. PF17 allows the worker to page through redeterminations month by month. PF18 allows an "X" to be placed by a particular number, then takes the worker to IQCP. This will provide information on who is in the case and the type of AGs involved.

Workers may enter redetermination interview slots into the system by using the Standard Day feature (CSSD) and the monthly schedule (CSMS) or they may use the daily schedule (CSDS). The worker should ensure that he has enough slots to accommodate the number needed as indicated for the month on IQRE. The worker does not input the case name or number. CSDS must show begin time, end time, appropriate Activity Code of "03" for redetermination, and number of appointments as "1". The scheduler runs on or about the 13th day of the prior month. If a worker knows that an individual can only come in at a certain time, the worker may schedule that person in advance of automated scheduling. The system will check, find the person already scheduled, and not schedule another appointment.

The Exception Report is generated by ICES and sent to Local Offices. This report indicates those clients that could not be scheduled. The worker must schedule those individuals himself by going to CSDS with an appropriate slot and entering the name and case number of the individual. The

appointment must be scheduled far enough in advance to accommodate the 10 working day requirement for notices.

ICES generates a redetermination appointment notice to inform the AG payee or authorized representative that a redetermination is due and the date and time of the redetermination interview appointment, if the appointment is scheduled at least 10 days in advance. If the appointment is not scheduled 10 days in advance, a manual appointment notice must be sent. A copy needs to be retained by the worker.

If a client calls the worker and requests to be rescheduled, the original appointment may be deleted on CSDS by the worker and the individual rescheduled to another slot by the worker. Only the rescheduling portion of this process can be completed by clerical personnel.

When ICES schedules redeterminations all the unique payees in a case receive a notice with the same appointment time.

ICES can only schedule if there are redetermination appointment slots available. The schedules must be monitored to be sure there are enough slots available each month.

(See IPPM 1835.05.00 regarding exceptions to the in-office interview.)

2210.00.00 PROCESSING REDETERMINATIONS

The ICES redetermination driver flow is initiated by invoking the AEORE transaction. It retains case information and blanks out appropriate verification codes. These blanks must be re-entered as information with appropriate verification codes is required to be reverified during and subsequent to the interview.

The redetermination process is to be initiated (Tran AEORE invoked) after recur of the last month of the certification or during the redetermination month. For example, if the redetermination month is March, AEORE may be invoked after recur is run in February or any time in March. If a TANF or Medicaid redetermination month must be changed, AEWAA must be accessed and the redetermination month changed. AEORE may then be invoked. It is never appropriate to change a Food Stamp certification period once authorized. The Food Stamp redetermination month cannot be changed on AEWAA once the AG has been authorized.

2210.05.00 TIMELY SUBMISSION OF THE APPLICATION (F)

To be considered timely, the application must be submitted by the 15th of the last month of the certification period.

The recertification process in these cases is as follows:

The interview is scheduled by the 20th of the month (30 day month) or 21st of the month (31 day month) in order to ensure uninterrupted benefits;

10 days are allowed following the interview date for verification to be returned; and

the recertification is authorized by the end of the month.

In the event this time frame is not met, the caseworker will determine who caused the delay. If the applicant did not miss a scheduled interview and provided the information requested within 10 days, any delay must be considered agency delay. The timely resubmitting of the application and required verification would entitle the recipient to benefits for the following month on the regularly scheduled issuance date. Refer to Section 1825.45.00 for interview criteria for expedited AGs.

If the timely filed application results in a denial, action should be taken at the end of the last month of the certification period.

2210.05.05 Untimely Submission Of The Application (F)

If the application for recertification is received after the 15th of the last month of the certification period, it is considered an untimely submission. Processing time standards are altered for untimely applications.

The following application standards apply for untimely applications:

The application is to be processed by the 30th day after filing; and

The caseworker will allow 10 days from the date the verifications are requested, or 30 days from the date the application is filed, whichever is later, for the AG to provide verifications and assure uninterrupted benefits and entitlement. If the AG does not provide verification by the 30th day, the application is denied. The AG must file a new application to have eligibility redetermined. Benefits will be prorated from the file date of the new application.

2210.05.10 Determining Eligibility And Benefit Level (F)

If an application is filed following any break in assistance of more than one day, benefits will be prorated from the date of the application. Migrant/seasonal farm worker AGs

are not prorated unless there is a 30-day break in assistance. That is, if a migrant/seasonal farm worker Ag received benefits anywhere in the last 30 days, the benefits will not be prorated at application point.

2215.00.00 CHANGES

The individual may report a change in circumstances or the Local Office may learn of a change which could affect eligibility or the benefit amount. The caseworker is responsible for promptly evaluating the change and taking any indicated action to adjust the benefit.

Changes in circumstances include, but are not limited to:

Changes in income or child care expenses;

change in composition of the AG;

change in living arrangement;

change in a child care provider's situation;

change in resources;

an unanticipated change in IMPACT or work registration status; and

changes in the legal obligation to pay child support.

2215.05.00 CHANGES THAT ARE REQUIRED TO BE REPORTED (F)

Food Stamp AGs which contain all elderly and/or disabled members and have a twelve month certification are required to report the following changes that occur between application and recertification points for any AG member: (f3)

Changes in wage rate or salary or a change in full-time or part-time employment status;

Changes in the gross monthly unearned income of more than $50 (except changes in the TANF grant);

Changes in individuals residing within the household;

Changes in residence and the resulting change in shelter costs;

Changes in ownership of licensed vehicles;

Changes in the liquid resources of any AG member, which causes the total resources of the AG to exceed $3,000; and

Changes in the legal obligation to pay child support (regardless of the amount being paid).

Food Stamp AGs that are subject to simplified reporting requirements (all AGs except those consisting of all elderly/disabled members) must only report whenever the AG's monthly income exceeds the gross monthly income limit for the AG size. Other changes may be reported by the AG and if reported, must be acted upon. There is no penalty for the AG failing to report other changes.

A change which results in the AG exceeding the gross income limit must be reported by the 10th day of the month following the month exceeding the gross income limit in order to be considered as timely reported.

2215.10.00 DATE CHANGE REPORTED

The date a change is reported is the date on which an individual reports the change in person, by phone, or in writing to the Local Office. This includes speaking directly to the caseworker or other staff member and leaving messages for the caseworker. All reports of changes are to be accurately documented in Running Record Comments and should be entered in ICES the same day the change is reported. ICES establishes the date that the information is entered in the system as the date it was reported. The "occur date" is the date on which the change actually occurred.

Local offices must adhere to the following procedures for date stamping information left in a local office drop box from a client and/or others. This includes, but is not limited to verifications, applications and hearing requests. This allows for a consistent procedure to follow when processing cases and performing other duties.

1. The drop box should be <u>emptied immediately</u> every morning at a specified time of no later than 8 A.M. and the date of receipt is considered to be the previous business day. If the drop box is opened on Monday morning and the office was closed on the previous Friday, the receipt date would be considered Thursday. Whatever information was left in the drop box that is emptied immediately in the morning should have the previous business date stamped on the information.

2. If the drop box information cannot be date stamped at the time it is emptied, it shall be placed in a container to be date stamped later in the day. A note shall be left on top of all of the drop box information with the date that is to be stamped.

3. If the drop box is emptied at other times later in the day after the initial time, then the date stamp shall be that business day. If this information cannot be date stamped at the time it is emptied, follow instructions in item 2.

4. No exceptions are allowed for opening the drop box late for the initial time in the morning. It must be emptied immediately every morning at a specified time of no later than 8 A.M. to provide a consistent receipt date of information and good customer service.

2215.15.00 CASEWORKER RESPONSIBILITIES REGARDING CHANGES

Prompt action must be taken on all changes to determine if they affect eligibility. The case record must include the date the reported change was received, whether the change was reported by mail, telephone, or personal visit, the nature of change and any other appropriate information. The caseworker must take appropriate action on all reports of changed information promptly but no later than 10 days from the date of the receipt of the change.

The individual must be notified of any change in eligibility or benefit. In addition, if the change was reported by the AG, the AG will be notified even if there is no change in eligibility or benefit amount.

If the caseworker is made aware of discrepant information or information that could affect eligibility or level of benefits, but lacks enough information to determine the effect, he will issue a request for verification. This request should be issued on the date of receipt of the change if at all possible, outlining the needed information or verification, and giving the AG 10 days from the date the notice is issued to provide the information.

If the AG provides the requested information or verification within the designated 10 day period, the caseworker will take appropriate action. If the AG refuses to provide the requested information or verification within the designated 10 day period, the caseworker will, on the first day following expiration of the 10 day period, take action to recalculate eligibility and authorize the appropriate action for each AG. The caseworker must enter the appropriate reason code on AEWAA which reflects the element which the AG did not verify.

Food Stamp AGs that are subject to simplified reporting requirements (all AGs except those consisting of all elderly or disabled members) must only report whenever their income changes in an amount to exceed 130% of poverty (the maximum gross amount) for the AG size. This must be reported within 10 days from the end of the month in which the change

occurs. No other changes are required to be reported by these AGs. However, the AG may report any changes and if reported, the changes must be verified and acted upon by the worker. See 2215.05.00.

For Food Stamps only, an exception exists regarding changes in medical expenses. A Food Stamp AG cannot be required to report a change in medical expenses or provide verification of medical expenses during the certification period. If a new or different expense is reported but not verified, only those expenses which were verified previously must be left in the food stamp budget until the Assistance Group is recertified.

If a potential change in medical expenses is identified when the AG presents verification of expenses to meet the spend-down, the AG may be asked to confirm if a change has occurred. If the AG voluntarily provides all verification and information necessary to process the change, including the frequency of any new expenses and possible third party liability, the change must be processed. If the AG is unable or unwilling to provide the necessary information/ verification, the change cannot be processed because the AG is not required to report or provide verification of medical expenses.

All medical expense changes identified from sources other than the household will not be acted upon unless all necessary verifications are obtained and action can be taken without contacting the AG. Claims will not be established nor will auxiliaries be provided to AGs that choose not to report or verify medical expenses.

2215.15.05 Deleting Data

It is very important to review the data on a screen before deleting it. If there are any question marks in verification fields, DO NOT delete the data.

When data has expired (for example, a person leaves the case while the application is still pending or a vehicle is sold), always check to see if ED/BC has pended the eligibility result. If it is pending, it is due to incomplete verification. DO NOT delete the data until the appropriate verification code is entered.

2220.00.00 PROCESSING CHANGES

Individuals are given 10 days to report the change, 10 days to verify the change, and if the action is negative, 10 days (plus three days for mail delivery) timely notice of adverse action. This processing time frame is referred to as "10, 10, 10". If the individual is doing all that he can to cooperate in verifying the information but is unable to do

so, an extension may be granted or the Local Office may accept the responsibility of verifying the information. Document the reason for any extension in Running Record Comments. In either instance, if the individual and the caseworker are unable to adequately verify the information within a reasonable time, the caseworker is to use the best available information to process the change and document in Running Record Comments.

When it becomes necessary to take adverse action (that is, reduce the benefit level) on an AG, there must be time to give advance notice of the adverse action. This is referred to as timely notice. The time period is 13 calendar days for all programs.

The following sections discuss change processing.

2220.05.00 CHANGES REPORTED AND VERIFIED TIMELY

When a change is reported within 10 days of the date the change occurred and is also verified within 10 days of the report date, action is taken as indicated below:

When a change results in a positive action or increases the level of benefit, including the addition of a mandatory AG member, the effective date of the change is the month following the month the change was reported.

EXAMPLE:

An individual reports on 7/25 that his last day of work was 7/16 and his last paycheck will be 7/26. He provides a statement from his employer on 7/30 (within 10 day guideline). The earnings are removed from the budget effective 8/1.

If the AG's benefit level decreases or the AG becomes ineligible as a result of the change, the decrease in the benefit level is effective the month following the expiration of the timely notice period.

2220.10.00 CHANGES REPORTED UNTIMELY YET VERIFIED TIMELY

If a change is not reported within 10 days yet is verified within 10 days following the report date, action is taken as indicated below:

When the change results in an increase in benefits or other positive action, the change is effective the month following the date reported.

EXAMPLE:

An individual is fired from his job on 6/3 and received his last paycheck on 6/23. He calls his caseworker to report the change on 6/28. On 7/3 he brings in his last paycheck stub. The caseworker verifies by phone that his last day was 6/3 and his last pay was 6/23. The loss of earnings are reflected 7/1 with a supplemental benefit being issued for 7/1.

When the change results in a decrease in benefits or the AG becomes ineligible, the change is effective the month following the expiration of timely notice.

EXAMPLE 1:

A TANF child moves to Texas to live with his father on 6/3. His mother calls on 6/28 to report the change and provides the new address on 6/30. Since this child is the only eligible child, the case is discontinued effective 8/1.

EXAMPLE 2:

An individual begins a job on 5/26 which he reports to his caseworker on 7/19. His earnings reduce his benefit effective 9/1. Recovery is pursued for July and August. Refer to Chapter 4600.00.00.

2220.10.05 Changes Resulting In An Increase Not Verified Timely (F)

When an AG reports a change that increases Food Stamp benefits, a written notice should be sent to the AG requesting verification and allowing 10 days to provide the verification. If the verification is not provided by the 10th day, the benefits should continue at the current amount until the end of the current certification period. When the untimely verifications are provided, the increase shall be implemented from the date the verification is provided rather than from the date the change is reported.

This section only applies to reported change(s) that will increase benefits such as:

Adding a member with zero income,
Decreases in countable income or allowable expenses from previously verified sources.

Example: The AG reports on 5/25 that a member has lost his earned income. The AG is given until 6/4 to provide the verification. If the AG provides the verification by the deadline, the benefits are increased to reflect the change for June benefits since the change resulted in an increase in benefits. (A supplemental will be required.)

If the same AG failed to provide the verification by the deadline, the benefits would continue at the same amount for June and subsequent months. If the AG provided the verification on 6/10 the increase benefits should be reflected in the July budget. No restoration is given for June benefits.

This section does not apply when non-financial or resource changes that may make an individual or the entire AG ineligible are reported. When these types of changes occur alone or with a change that would increase benefits, all changes must be verified. Failure to verify all reported changes will result in termination for failure to cooperate in establishing eligibility.

EXAMPLE:

The AG reports that Aunt Betty has moved into the home, verifies her presence but fails to verify her income within 10 days as requested. The CW will propose closure for failure to provide necessary information

EXAMPLE:

Same situation as above but Aunt Betty has no income. She has other non-financial verifications (citizenship, Cooperation with Work Programs, etc.) pending beyond 10 days. Although adding her appears to be a positive change resulting in an increase because her non-financial eligibility has not been determined, she cannot be added until she has complied. In this case, closure for non-compliance would not be proposed.

2220.15.00 FAILURE OF ASSISTANCE GROUP TO REPORT CHANGES

If the Local Office discovers that the AG failed to report a change as required above and as a result received benefits to which it was not entitled, a referral is made to Benefit Recovery (BV) on screen BVBR to initiate claim determination and benefit recovery.

For FS, the AG will not be referred to BV because of a change in circumstances that it is not required to report.

2220.20.00 AGS WHICH SPLIT UP DURING AN ENTITLEMENT PERIOD (F)

In the month when the original AG separates, no additional benefits are due to any departing member if he participated as a member of the original AG during that month. The exception to this policy is the battered spouse. Refer to Sections 3210.15.25 and 3210.15.40.

The caseworker must act on a reported change within the specified time period. A notice of decision reducing its allotment will be sent to the original AG. If the adverse action period expires after the beginning of the following month, its allotment cannot be reduced until the subsequent month.

2220.22.00 REPORT OF NEW JOB THAT REDUCES FS ALLOTMENT (F)

When a client reports earned income from a new job that will decrease their FS benefits, the Caseworker must implement the change by the next adverse action deadline whether or not verification of the change has been received.

> For example; a client reports new employment on April 13 which will cause a decrease in FS benefits for May, the new income must be projected and authorized by April 15 which is the last day to authorize adverse action for May.

The Caseworker must attempt to secure verification by using all available resources. If this attempt is unsuccessful or incomplete, the new income that the client anticipates receiving must be projected using the best information available. If the worker is unable to obtain verification before the adverse action deadline, it is permissible to use the "client's statement" (verification code CS on AEINC) to meet this deadline pending receipt of verification from the client or the employer.

Because verification of a new source of Earned Income is mandatory for FS, TANF and certain Medicaid categories, the Caseworker must continue to pursue verification even after the new job is authorized with the CS code. As stated above, verification will be obtained as usual but in many cases it will be received after the next adverse action deadline and the income from the new job has already been authorized. The four paragraphs below explain what the Caseworker must do to complete the verification process after the new job is authorized with CS.

If the verification received after the new income was authorized with "CS" confirms that the initial projection is accurate, no other action than documentation of this decision on CLRC is necessary.

If verification received after the authorization using "CS" shows that a different amount of earnings is expected for future months, it should be processed as another change. An auxiliary may be needed for the next calendar month if verification is received after the recurring run but before the first of the next month and indicates a decrease in income from what is projected for the next month. There is no need for a claim if the original projection was incorrect due to inaccurate information provided by the client or employer. A claim would only be "opened" if it is determined by a court or Hearing Officer that the client committed an Intentional Program Violation in relation to the reporting of the new job.

If the client does not cooperate with the worker's request for verification, assistance for all programs that require verification of income may be terminated in accordance with Section 2220.00.00.
If the client is cooperative but unsuccessful in obtaining verification, the caseworker must assist the client and/or grant an extension for the client to try to obtain verification from an alternate source. In either case it may be necessary to use the best available information.

This policy will only be applied when a new job is reported that decreases benefits during an existing FS certification period; however, all program AG's may be authorized with the "CS" code for the new job if they are "pass-pass" on AEWAA. If only MA and/or TANF AG's are present in this case, this policy is not applicable and the case can be pended as usual for verification.

No other changes in earned income will be authorized without verification. All earned income must be verified at the time of recertification, redetermination or application. This policy does not apply to self-verified employment which is routinely verified with "CS" when there is no other source of third party verification.

Suggestion-Review all pending changes on the adverse action deadline and authorize all adverse changes due to a new job on that day using the best available information. All FS cases with earned income are subject to Second Party Review by the Supervisor to ensure that this procedure is only used for "new" jobs. A new job is a job that has not been previously reported and the earnings included in the FS budget.

Quality Control Review Guidelines are not affected by this policy. Errors caused by failure to budget income from a new job that was reported will continue to be excluded if the new job began during the 23 days immediately preceding the review month, (33 days for unreported jobs).

2220.25.00 PROCEDURES WHEN MEDICAID FACILITY LOSES CERTIFICATION

When a Medicaid-certified long term care facility receives notification from the Department of Health that its Medicaid provider agreement will be terminated, a copy of the notification is sent to the Local DFC Office. Generally, the facility is given 30 days advance notice of the loss of certification. However, the facility does have appeal rights. If the facility appeals and the Department of Health rules that the patients are not in immediate and serious danger, the facility's Medicaid certification may be allowed to continue during a specified period of time while the deficiencies cited by the Department of Health are being remedied.

The Local Office will need to stay in close communication with the facility concerning the facility's continuing Medicaid certification. Steps to change the recipients' data in ICES (Screen AEIII) should not be undertaken immediately by the caseworker upon receipt of the initial decertification letter. The facility's appeal status and any subsequent rulings of the Department of Health must be ascertained. If the caseworker cannot obtain the necessary documentation from the facility, the Central Office, Policy Answer Line, should be contacted.

2225.00.00 <u>ADDING AN INDIVIDUAL TO THE AG</u> (F, C, MED 2, MED 3)

When a request to add an individual to the AG is received or a mandatory AG member enters the home, all eligibility factors must be reviewed.

An interview is not necessary, but all of the required information and verification regarding the new member must be obtained in order to make an eligibility determination and add him to the AG.

The new member is entered on AEIID. Pertinent information is then added to the appropriate screens as they appear. The CAF is to be printed for the payee or authorized representative to sign. This ensures that any work registration, medical support/child support assignment, or citizenship declaration requirements of the various programs are met for the new AG member. Another condition of eligibility which is satisfied by a signed CAF for the new

person is the requirement to complete an application when adding an optional member to the AG. (f4) After the signature is obtained (in person or by mail) the AG, if correct, may be authorized on AEWAA. The system will generate a notice to inform the AG of the results. If adding a mandatory member causes the AG to lose eligibility for cash assistance, ICES will explore continued Medicaid eligibility under other categories.

For MED 2, 3 only: To provide the new member with retroactive coverage, it will be necessary to fiat to create an AG (consisting solely of the new person or persons) for the retroactive months. The sequence number to be used for the retroactive AG will depend upon the number already in use for the first AG. If the sequence number for the original AG is 01, the sequence number for the fiated AG will be 02. Additionally, it is important to remember to end-date the fiated AG appropriately.

For Food Stamps, **and** cash assistance only: When an individual must be added for the next month and the cut-off date has passed, auxiliary benefits (if appropriate) must be issued. NOTE: Reference table TBIC displays cut-off dates. For information concerning the issuance of auxiliary benefits, see Chapter 3600.

2225.05.00 EFFECTIVE DATE FOR ADDED INDIVIDUALS (F, C)

The effective date for added individuals is the first of the month following the date of request when verification is provided timely. For cash assistance only, the effective date for an individual for whom an application must be completed is usually the first of the month following the application date. However, if the application is filed on January 1, March 1, May 1, July 1, August 1, October 1, or December 1, benefits are effective the 31st day of the application month.

2225.10.00 ADDING A NEWBORN CHILD (MED)

A baby born alive to a woman who is eligible for MA under <u>any</u> category (other than MA 10) on the date the baby is born is to be immediately added to the ICES case. This includes a baby who is added to a TANF grant, and whose mother is receiving MA C. In this situation, the newborn is approved under the MA X category. Health coverage is effective the first day of the month in which the child is born and is always approved for at least the birth month (for example, in cases of adoption).

MA X coverage may be initiated based on notification of the child's birth by the parent, hospital or any interested party who has the child's interest in mind and can provide

the required information. Sufficient information would include the child's name, sex, and date of birth. The parent is not required to request coverage or submit an application.

If the Newborn continues to live with his mother, an alert is generated to the caseworker near the end of the one year eligibility period. This alert instructs the caseworker to run ED/BC so that eligibility under other medical categories is explored and verified.

This automatic eligibility does not, however, extend to babies born to mothers covered under the MA 10 category. For them, eligibility must be determined without regard to the mother's coverage. Although a baby born to a mother receiving coverage under Hoosier Healthwise Package C, is not automatically deemed eligible under the MA X category, an application must be expedited, upon request by the parent or other caretaker in the home, or notification of the birth by the hospital. An application for Hoosier Healthwise must be immediately provided or mailed to the family and a telephone interview scheduled. Hospitals and other Indiana Medical Providers that are Hoosier Healthwise enrollment centers should be encouraged to take the applications for newborns. They will know the eligibility status of the mother by using their AIM Eligibility Verification System which will indicate the benefit package of the mother.

2225.15.00 THE TANF FAMILY BENEFIT CAP (C)

The policy in this section affects the ADCU, ADCR and ADCI categories of cash assistance. It applies only when the assistance group whose eligibility is determined under one of those categories has been assigned to the treatment group of the Welfare Reform Demonstration Project.

The TANF grant amount will not be increased to add a child who was born more than ten calendar months after the initial effective date of TANF benefits.

The provision also prohibits an increase of the TANF grant for any additional individuals who, because of a parental or sibling relationship to the baby, would have been mandatory additions to the participating assistance group under traditional AFDC rules.

This policy pertains solely to the TANF payment calculation and the resulting benefit amount. The baby and his parent and siblings in the home (if eligible under traditional AFDC rules) are:

TANF recipients;

Eligible for Guaranteed Child Care (GCC);

Eligible for AFDC/TANF-related Medicaid (the baby, however, would receive Medicaid for Newborns until age 1); and

Subject to all program requirements such as IV-D assignment and cooperation, signing the Personal Responsibility Agreement, and cooperating with the immunization and school attendance requirements.

Once correctly applied, the family cap exclusion would continue if the assistance group were to lose and then regain TANF eligibility.

The benefit cap provision does not apply:

To babies born into assistance groups which are assigned to the control demonstration group;

When the baby was conceived as a result of incest or rape as verified by a physician's statement and police records;

When the baby (or babies in the case of a multiple birth) is the first born child of an assistance group member who is a minor;

When the baby resides with a non-parent caretaker and his parents are not in the home; or

When the baby was conceived in a month in which the parent was not a member of the TANF assistance group. If both of the child's parents are in the assistance group, both must have been non-recipients when the child was conceived. (NOTE: A baby which was conceived in a month in which the parent was excluded from the benefit because of a non-compliance sanction or the expiration of the parent's 24-month benefit period will not receive the exemption.); or

When the baby has a substantial physical or mental disability at birth (as verified in writing by a licensed physician).

With the exception of the factor involving the month of conception, the circumstances can be verified by accessing pertinent ICES screens and obtaining written statements from objective third party sources who have knowledge of the situation. If it is possible that the caretaker relative was not a recipient when the baby was conceived, an approximate date of conception must be established. This is calculated by subtracting nine months from the estimated due date as provided by the mother's physician.

All statements, evidence and arithmetic calculations pertaining to the benefit cap determination must be fully documented in hard copy form where appropriate and/or on the Running Record Comment Screen (CLRC) on ICES.

When an AG reports the birth of a child, it is first necessary to establish:

> Whether the baby would be a mandatory participant in the assistance group under TANF rules (that is, whether the baby is full or half-sibling to at least one child in the assistance group and the baby meets the definition of "deprived child" as discussed in Section 2418.00 of the IPPM); and
>
> Whether the baby is subject to the benefit cap provision.

If the child is found to be a mandatory assistance group member who is subject to the benefit cap provision, the next step is to consider the income and needs of all individuals who would be mandatory assistance group members under traditional rules, including the baby and his siblings and parents in the home. Assistance will continue only if the assistance group remains eligible when all mandatory members' income and needs are included in the eligibility determination. If the assistance group is ineligible, action will be taken to discontinue the TANF benefit for the entire family.

When including the baby and the additional family members he draws in results in continuing TANF eligibility, the payment calculation for the original assistance group members is performed as if the baby had not been born. (His income and needs and those of his relatives who would have been drawn into the assistance group under traditional AFDC rules are totally excluded.)

The functions of determining eligibility and then calculating the payment amount are performed by ICES according to the information coded onto the system by the caseworker. The child's demographic information must be coded accurately on AEIID to ensure that ICES uses the correct date of birth in determining whether the family benefit cap should be applied. It is also vital that the exact relationship of the baby to each household member is captured on the Household Relationship Screen (AEIHH). Adding the baby to the case as a new household member on the Individual Demographics Screen (AEIID) will cause the Treatment Group Requirements Screen (AEWRT) to appear.

Based on the data entered on other screens by the caseworker, AEWRT will show whether the family benefit cap applies to the child in question. If the "Family Cap?"

field shows "Y" for the child and no exception reason code is entered, the baby and any individuals he draws in will be excluded from the TANF payment. It is important to remember that ICES cannot recognize a circumstance of the child's conception or birth which would constitute an exception to the benefit cap rule if there is no data pertaining to it on the system. Therefore, situations which are not addressed in the ICES driver flow (conception in a month in which the parent was not an TANF recipient; child of a first-time parent who is a minor) must be coded as exemption reasons on AEWRT by the caseworker after an off-line determination has been made. The reason codes for exemption from the family benefit cap are found in ICES Table TFCR (Family Cap Reasons).

If a baby is not subject to the benefit cap provision because he/she was conceived as a result of incest or rape, the caseworker is likely to discover it indirectly when adding the baby to the ICES case. (The mother, when informed of the requirement to name the absent father and cooperate in obtaining child support, would explain her hesitation to do so by discussing the circumstances of the child's conception.) Verification of this circumstance would serve the dual purpose of allowing an exception to the benefit cap for the baby and identifying potential good cause for the mother's failure to cooperate with IV-D requirements. (See IPPM, Section 2436.10.10.05 for information regarding child support good cause circumstances.)

Prior to authorizing the exclusion of a newborn from the payment, the caseworker may access the Pregnancy Information Screen (AEIPI) to determine the date of conception. The "month due" field will indicate the expected delivery month. By subtracting nine months from the expected delivery date, an estimated date of conception can be determined. (Note: Medical documentation of a gestational period longer or shorter than nine months would supersede this method of determining the month of conception.) If the Individual Eligibility History (IQEL) does not indicate parental participation in TANF during the month of conception, the exception to the family benefit cap applies. When pregnancy information has been deleted from ICES and IQEL data indicates the possibility that the benefit cap exception applies, medical documentation must be requested if it is not available in the case file.

In the case of a minor recipient who becomes a parent, it cannot be assumed that because the minor has no other child in the home, the newborn is the minor's first-born child. Therefore, it is the caseworker's responsibility to determine whether or not the newborn should be included in the TANF payment by asking the minor if she has given birth to or he has fathered other children. (Note: If the

assistance group includes two minor parents, both must be asked the question.) Written statements may be requested and should be maintained in the case file. However, refusal or failure of the minor parent to provide a statement does not affect the minor's or the assistance group's TANF eligibility other than to preclude making an exception to the benefit cap provision for the newborn.

As indicated previously, individuals who are excluded from the TANF payment due to the family benefit cap are, nevertheless, TANF recipients and are expected to meet all TANF program requirements. Therefore, if an excluded adult refuses or fails (without good cause) to cooperate in a child support or IMPACT activity, an individual sanction is applied to his TANF-related Medicaid benefit. The penalty period is equal in length to the sanction imposed (for the same non-compliance) on an individual who is included in his assistance group's grant. As with other TANF-related Medicaid sanctions, it will be necessary to fiat coverage if the individual qualifies for Medicaid under a non-TANF related category.

A $90 fiscal penalty (rather than an individual sanction) is imposed on the assistance group of an adult excluded from the TANF payment under the benefit cap provision who:

Fails or refuses, without good cause, to sign the Personal Responsibility Agreement;

Fails or refuses, without good cause, to comply with school attendance requirements;

Fails or refuses, without good cause, to comply with immunization requirements; or

If assigned to the placement track, fails or refuses, without good cause, to develop a self-sufficiency plan or perform the required activities included in a self-sufficiency plan.

Consistent with the procedure for non-compliant participating assistance group members, the $90 fiscal penalty is removed when the benefit cap-excluded individual comes into compliance.

Unless otherwise exempt from the family benefit cap provision, a mutual child born to parents living in the same home and heading separate TANF assistance groups (ADCR/01 and ADCR/02) is excluded from the TANF payment of either assistance group. The continuing TANF eligibility of the family is determined according to the guidelines previously stated. However, because of the sibling relationship between the newborn and the children in the two assistance groups, it is first necessary to determine whether his or

her presence in the home requires the assistance groups to combine into a single TANF assistance group. The outcome depends on whether the newborn is deprived of parental support due to the unemployment or underemployment or incapacity of one of the parents. (See IPPM, Sections 2418.10.00 through 2418.15.00 for information regarding these deprivation factors.)

If the newborn does not meet the deprivation requirement, the assistance groups remain separate and all family members are eligible for TANF and TANF-related Medicaid except for the baby. (Note: Since the mother was a Medicaid recipient on the date of birth, the baby would be eligible for Medicaid for Newborns (MA X).

If the newborn is found to qualify as a deprived child, the two assistance groups must be combined to form a single assistance group based on the incapacity or unemployment/underemployment of a parent. The TANF eligibility determination would include the income and needs of the baby, his parents and his siblings. The TANF payment calculation would include both of his parents as well as his siblings who were participants in the ADCR assistance groups, but not the newborn. He would receive Medicaid For Newborns for one year prior to receiving TANF-related Medicaid.

EXAMPLE 1

Joseph and his son receive TANF (ADCR/01). Helen and her 3 children receive TANF as a separate assistance group (AFDC/02). They are not married. Joseph and Helen have a child (Angelo) together one year after Helen starts receiving TANF. Joseph was last employed six years ago and Helen (the primary wage earner) works 150 hours per month. Neither parent meets the TANF definition of unemployed or underemployed parent. Neither parent is incapacitated. Therefore, the mutual child, Angelo, is not a deprived child under TANF regulations. The sibling relationship Angelo bears to the other children would necessitate the combining of the two assistance groups only if she met TANF deprivation requirements herself and thus, qualified for TANF-eligible status. Since she is not categorically eligible under traditional AFDC rules, the assistance groups remain separate and Angelo does not acquire TANF-eligible status Angelo will receive Medicaid for Newborns. {Note: ICES will allocate a portion of Heavens income to Angelo (as Heavens non-recipient child) in the budgeting for Heavens assistance group. This process is totally unrelated to the family benefit cap determination and occurs whenever the TANF recipient parent of a non-recipient child has income. See IPPM Section, 3450.40.10 for information regarding the allocation process.}

EXAMPLE 2

(See Example 1.) Several months later, Helen is laid-off from her job. Since she is the primary wage earner and has sufficient work history, Helen meets the TANF definition of unemployed parent. Angelo now fulfills the TANF categorical requirement that she be deprived of parent support. Therefore, she is now a mandatory member of an ADCU (Assistance to Families with Dependent Children-Based on the Unemployment/Underemployment of a Parent) assistance group. The new assistance group also includes both of her parents and all of her half-siblings (the former ADCR/01 and ADCR/02 assistance groups combined). Everyone is included in the TANF eligibility determination, but Angelo is excluded from the TANF payment.

2230.00.00 ENTITLEMENT WITHOUT VERIFICATION OF DEDUCTIBLE EXPENSES (F)

If a deductible expense must be verified and the verification is not provided by the 30th day, the AG must be

advised that its eligibility and benefit level may be determined without providing a deduction for the claimed, but unverified, expense.

If, after entitlement, the AG provides the missing verification, the caseworker will redetermine the AG's benefits and provide increased benefits, if any, in accordance with timeliness standards for changes within an entitlement period.

If an expense is disallowed, the AG will be entitled to restoration of any benefits lost only if:

The caseworker failed to allow the AG the full 10 days from the date of the request for verification; or

the expense could not be verified within the 30 day period at application.

If the AG would be ineligible unless the expense is allowed and there is a delay, the AG's application will be handled in accordance with Chapter 2020.20.00.

2232.00.00 TIMELY NOTICE OF ADVERSE ACTION

Recipients must be given timely, advance written notice of any adverse action. In most circumstances, "timely" is 10 days (plus 3 for mailing) before the date the action is effective. The 3-day mailing period starts the day after the notice is mailed. The monthly Adverse Action dates are located on table TBIC. The Food Stamp and Medicaid programs have provisions which allow for exceptions to the 10 day (plus 3 for mailing) timely notice period. However, there is no such exception for TANF recipients. The following sections explain the FS and MED timely notice exceptions.

Caseworkers should carefully choose the reason code to be entered on AEWAA. It must be appropriate to the program and if timely notice is not required, enter a code with a priority of 1 on the TSRC Table. If a negative code in addition to the 650 code is not already displayed, the worker will be required to enter one. It is necessary to select the reason code carefully so that the notice will correctly reflect the reason benefits are terminating.

2232.05.00 EXCEPTIONS TO TIMELY NOTICE (F)

The following are the only reasons a case may be exempted from advance (13-day) notice of adverse action:

Mass changes; instructions for providing notice will always originate from the State level.

The Local Office has received reliable information that:

- All members of the AG died;

- the AG has moved out of the state; or

- the AG will move out of the state prior to their next scheduled issuance date. Notice of cancellation must be sent prior to the AG's next scheduled issuance date.

The AG chose to receive its restoration over several months, and the restoration is completed, IF the AG was notified in writing of when the restoration would be completed.

The AG's allotment varies within the certification period AND the AG was notified of the changes at the time of certification.

The PA AG's TANF grant is added to the budget AND the AG was notified at the time of certification that its benefits would decrease when TANF was received.

An AG member is disqualified for IPV and benefits of the remaining members are reduced.

Postponed verifications are not provided or are provided and required reduction/cancellation of benefits IF the AG was notified at the time of certification that benefits would not be received after the month of application if verifications were not provided and that benefits would be reduced if verifications required such.

The AG's allotment is reduced to make a claim repayment because the AG did not make the agreed upon repayment.

The AG voluntarily withdraws from the Food Stamp Program in writing or verbally to the worker. The AG must be notified to confirm a verbal request to the worker.

2232.10.00 EXCEPTIONS TO TIMELY NOTICE (MED)

The following situations do not require timely notice, but do require notice to be sent no later than the effective date of action: (f5)

The Local Office has factual information confirming the death of a recipient;

The Local Office has received a written voluntary withdrawal of assistance;

The recipient's whereabouts are unknown and Local Office mail has been returned by the Post Office indicating no known forwarding address; or

The Local Office has verified that the recipient has been accepted for assistance in a new jurisdiction (county, state, territory or commonwealth).

2234.00.00 CHANGES IN CATEGORY OF ASSISTANCE (C)

When a change in circumstances causes an AG to lose eligibility under one category, ICES (through failure logic) will fail the AG for that category and explore eligibility under other assistance categories. A new application is not needed to establish eligibility under a new category. With this process assistance should not be discontinued unless:

ICES determines that the recipients no longer meet any assistance category's eligibility requirements; or

The AG fails to provide verification required to establish eligibility under the new category.

Circumstances likely to generate a change from one cash assistance category to another include:

A change in household composition;

EXAMPLE 1:

Mrs. Bell has been receiving benefits for herself and her three children from a previous relationship under the ADCR category. Mr. Bell is unemployed and receiving FS only. Upon the birth of a mutual child, the entire family becomes categorically eligible under the ADCU category.

A change in employment status:

EXAMPLE 2:

Mr. Bell (see Example 1) begins working 101 hours per month. The AG is no longer categorically eligible for ADCU. The system will discontinue cash assistance for the mutual child and form ADCR for Mrs. Bell and the three non-mutual children (who remain financially eligible despite the income deemed from Mr. Bell).

A parent becomes incapacitated:

EXAMPLE 3:

Mrs. Bell (see Examples 1 and 2) is seriously injured and the doctor expects a long convalescence. Since her incapacity creates categorical TANF eligibility for the mutual child once again, ICES will form ADCI.

Once the appropriate screens have been run and the newly formed AG authorized, the system will generate a notice to inform the recipients of any change in benefit level or AG membership.

2235.00.00 CHANGES IN CATEGORY OF ASSISTANCE (MED)

RESERVED

2236.00.00 REDUCTION IN SCOPE OF MEDICAID COVERAGE (MED)

The following circumstances will result in the Local Office taking action to reduce the scope of benefits. These are adverse actions requiring timely notice.

A recipient formerly eligible for full coverage becomes eligible for QMB-only, SLMB-only. or QI coverage;

A recipient eligible for full benefits loses eligibility for payment of nursing facility services or Home and Community-Based Services due to a violative transfer of property;

A recipient who was eligible for full range pregnancy benefits becomes eligible for limited pregnancy benefits;

A recipient who was eligible for QMB-only coverage becomes eligible for SLMB-only coverage.

A recipient who was eligible for SLMB-only coverage becomes eligible for QI coverage.

2237.00.00 SUSPENSION OF MEDICAID BENEFITS (MED 1, 4)

If a change in circumstances causes temporary ineligibility for MA, the AG may be suspended. This can only be done in situations where it is reasonably certain that the recipient will again be eligible after the suspension.

A suspension can last no longer than two months. If after the suspension period the recipient remains ineligible, the AG is to be discontinued. (Timely notice is required.)

2238.00.00 DISCONTINUANCE

When an AG fails to meet the eligibility requirements of any category within a program, assistance is discontinued for that program. Discontinuance is effective the first day of the month following the expiration of the required timely notice.

2238.05.00 DISCONTINUANCE DUE TO DEATH (MED)

When a recipient dies, the living arrangement code on AEIDC is to be changed to "05" and the correct verified date of death is entered as the occur date. This action will invoke ED/BC and the AG can then be closed. This is crucial for Medicaid AGs because the fiscal contractor must have the correct date of death to ensure that claims will not be paid erroneously.

When an institutionalized recipient dies, the end date and delete code for death are entered on AEIII. This will bring up AEIDC where the living arrangement type of "05" and the date of death can then be entered.

It is important to allow ED/BC to run so that the individual is denied in ICES prior to deleting the individual. This ensures that the information is passed correctly to AIM.

2238.10.00 CLOSED CASE FILES

When all the AGs in a case are closed, the system will automatically transfer the case to closed files on the effective date of the discontinuance.

When someone in this case comes back in to apply for assistance, the client's information will be entered on ARAD and ARIR. ARIS will appear and the worker will identify the client as the same individual. ARCR will appear with the old closed number. The worker may elect to use the old number by putting an "X" in the select field. The system will retrieve the old information and the old case number will be the number attached to the current application. (The new application number goes away automatically - the worker does not deny anything.)

CLCA is to be used when transferring cases from one caseworker to another.

When the worker wants to access AE for this application, AECSQ is entered in the next tran and the new application number in parms. This will take the worker to AEICI with the old case number. The program choice will need to be changed and all information reviewed and verification codes entered during the AE process.

If a case is closed for which a future appointment has already been scheduled in the system and the notice has not

been sent, the appointment should be deleted on CSDS when the case is closed.

2238.15.00 CERTIFICATES OF MEDICAID COVERAGE (MED)

On August 21, 1996, The Health Insurance Portability and Accountability Act (HIPAA) was enacted. This law is designed to improve the availability of health insurance to working families and their children, including eligible individuals who have previous coverage under Medicaid. The provision of the law that directly affects the Division of Family and Children is the requirement concerning the issuance of certificates of creditable coverage. An individual, who enrolls in a health care plan that imposes an exclusionary period for a pre-existing medical condition, may be able to have that period reduced by prior coverage under another plan, including Medicaid. The Local Office must issue the Certificate of Medicaid Coverage (FI Form 0021) to the individual so that he can present it as documentation to the new health insurance plan. Periods of Medicaid eligibility beginning July 1, 1996 for all full coverage categories and pregnancy-related categories (MA N and MA E), except as explained below, are included as creditable coverage:

Exclude QMB-Only, SLMB-Only, and QI coverage. Unlike the pregnancy-related categories, these categories do not provide coverage of regular Medicaid services.

Exclude months of ineligibility for which a recovery claim has been established and is currently in dispute through the administrative hearing process.

Exclude months the person did not meet spend-down.

The following procedures are to be used when issuing the certificate:

1. The ICES discontinuance notices for reasons other than death of the recipient, contain the following paragraph which notifies the assistance groups that Certificates of Creditable Coverage are available upon request:

Important information about health insurance coverage. If you enroll in a health insurance plan that does not give you coverage for a preexisting medical condition, you may need to furnish proof of your Medicaid benefits. Ask the Plan Administrator of your health insurance about this. If you need proof of Medicaid eligibility, contact the caseworker whose name is on the first page of this notice and ask for a Certificate of Medicaid Coverage.

When it is necessary to issue a manual discontinuance notice (619M), caseworkers must include the above paragraph in the additional information section of the notice. If the recipient's Medicaid coverage since 7-1-96 consisted solely of QMB only or SLMB only, it is not necessary to include the paragraph. However, if since that time, the person had full coverage or pregnancy-related coverage, the paragraph must be entered on the notice.

2. Upon request by a former recipient, the FI Form 0021, Certificate of Medicaid Coverage, must be completed and mailed first class to the individual within 10 working days of the request. Local Offices are encouraged to try to accommodate requests made in person by giving the certificate to the individual at the time of the request. However, if this is not possible, the aforementioned time frame should be met. When mailing the Certificate, the current address should be obtained from the individual rather than relying on the last address in ICES.

As an alternative to mailing a Certificate, it can be faxed directly to the health care plan administrator or the information can be provided by phone to the administrator only if the following conditions are met:

The individual requests it; and

The alternative method being requested by the individual is acceptable to the plan administrator.

If the two conditions are not met, the Certificate must be mailed to the individual.

3. As a general rule, one Certificate is completed per family. However, separate certificates are to be provided if requested. This could be needed if, for example, children are being enrolled in different insurance plans held by non-custodial parents.

4. Enter the name and address of the local office and indicate the name and telephone number of a contact person in case the health insurance plan has any questions. This person can be the recipient's caseworker or anyone designated in the office to serve as coordinator for matters concerning the certificates.

5. Enter the name of each recipient in the family requesting the Certificate. Note that the Certificates do not necessarily have to correspond to the former assistance groups. For example, one AG may have been a child living with grandmother and the other AG in another case was the child's sibling and mother. When the certificate is requested, the mother and her 2 children are now living together. Unless there is a reason to issue separate certificates as requested by the family, or because there are too many eligibility periods, one certificate using all 3 recipients and their Medicaid coverage periods should be issued.

6. Enter the recipient's Medicaid number, i.e., the RID, not the case number.

7. List all creditable coverage periods after July 1, 1996 up to the present time without regard to category changes. For example, if a child was MA 2 from 1/1/97 to 6/30/97 and MA D from 7/1/97 to 9/30/97, the entry on the certificate would be

BEGIN 1/1/97 END 9/30/97

Coverage prior to July 1, 1996 should not be listed. If an individual had coverage prior to July 1, 1996 enter the begin date on the certificate as July 1996. If the person is currently on Medicaid, enter "currently covered" in the end date box.

The statement on the Certificate that periods prior to breaks in coverage may be included is information for health insurance companies only. The law specifies that certain coverage that has been interrupted cannot count as creditable coverage. The insurance company determines how creditable coverage is applied to an exclusionary period and the statement on the Certificate is simply to alert them to the fact that all coverage periods, regardless of breaks, are being reported on the form. The following are examples of how to enter eligibility periods on a Certificate:

EXAMPLE 1

Recipient was eligible from 10/96 through 11/97 with a spend-down. He met his spend-down in the months of 10/96, 12/96, 3/97, and 10/97. Entries on the Certificate should be listed as follows:

BEGIN	END
10/02/96	10/31/96
12/05/96	12/31/96
03/10/97	03/31/97
10/01/97	10/31/97

(Months that the spend-down is not met are not listed.)

EXAMPLE 2

Recipient was eligible for full coverage with a spend-down and QMB from 12/96 through 4/97. From 5/97 through 10/97 she was QMB only. Entries on the Certificate are as follows:

BEGIN	END
12/01/96	12/31/96
01/13/97	01/31/97
02/02/97	02/28/97
03/10/97	03/31/97
04/03/97	04/30/97

(The months of QMB coverage are not listed.)

EXAMPLE 3

Recipient was eligible with a spend-down from 1/97 through 12/97 and met his spend-down on the first day of the month. The entry on the Certificate is as follows:

BEGIN	END
01/01/97	12/31/97

(If spend-down is met in a month and then is met on the first of the following month, this is continuous coverage and the months do not have to be entered separately.)

2239.00.00 <u>CORRECTION OF SPENDDOWN AND LIABILITY</u> (MED 1)

If an authorized spend-down or liability amount is lower than it should be (for example, client or agency error, or hearing decision), recovery of any Medicaid overpayments

must be pursued in accordance with the provisions in Chapter 4600.

However, in specific circumstances, authorized spend-down and liability amounts which are higher than they should be can be corrected to a lower amount by using screen CUMED. Also, a spend-down can be changed to a lower liability amount; however, a liability cannot be changed to a spend-down. Acceptable reasons to use CUMED are as follows:

- Timely appeal filed after cut-off;

- Beneficial change timely reported and verified after cut-off;

- Agency error in calculation of spend-down or liability amount;

- Hearing decision decreased spend-down or liability amount;

- Court ordered decreased spend-down or liability amount.

No other reasons are acceptable in using CUMED. If a caseworker encounters a circumstance not listed above and feels the spend-down or liability correction should be made, the Policy Answer Line must be contacted.

When a change is made on CUMED for a given month, the "BNFT/S-L" field on IQAE for the eligibility segment containing that month, will be highlighted. This serves as an alert that at least one of the months in that eligibility segment has been changed via CUMED. AEBMB can be accessed to view the correct spend-down and/or liability amounts.

2240.00.00 AG CHANGES ADDRESS

When a client moves from one household to another it is suggested that the following procedures be used. The essential thing that must be remembered is that the Food Stamp certification period cannot be lengthened or shortened.

Following are a list of situations and what must be done to accommodate them:

All participating case members move to a different address with his household only (that is, not residing with other persons).

The address is changed on AEICI and any appropriate information (such as shelter expense) is changed. ED/BC is then run and the benefits are authorized.

Client moves from one active ICES case to another active ICES case;

The individual(s) must be deleted on AEIID from the first case and added on AEIID to the second. The individuals must be properly selected as the same persons in clearance.

When there are two Food Stamp AGs that move in together with different certification periods, and the AGs will continue to claim separate maintenance, the first AG to expire should be certified with a short certification period. When the Food Stamps from the second AG are expiring, the cases should be combined.

EXAMPLE:

Case A has Food Stamps which expire in October and Case B has Food Stamps which expire in December. In October certify Case A for November and December. In December combine the cases into one ICES case and certify both Food Stamp AGs for the appropriate certification period.

AG moves in with individual(s) who previously received assistance:

The inactive individual(s) should be added to the existing case on AEIID, but no program choice is made for them unless assistance is again being requested. The inactive individuals must be properly selected as the same person in clearance.

AG moves in with nonrecipients or nonrecipients move in with an existing AG:

The new nonrecipient(s) should be added on AEIID and all appropriate screens should be completed as they appear via the driver flow.

AG moves out of a household which contains other active AGs who will be maintaining their eligibility for assistance:

The case members who left the case should be deleted on AEIID using Delete Code "LC". If these individuals move into a household that does not contain an ICES case, they will need to be entered in AR to get a number. The individuals should be chosen on ARIS to indicate they are the same

individuals as in the previous case. ARCR will display their previous case with an active status, but that number cannot be used. The new application number will be retained unless the person has an old inactive number which can be used. In either case, when the individuals are selected as the same people, their information will be retrieved. This information will have to be reviewed in the AE process and the "new" case authorized. For Food Stamps, the current certification period must be maintained; therefore, the redetermination date must match the old redetermination date.

AG moves from a household which has no other active AGs (all other AGs are closed or denied):

The same number can be used, a new number assigned, or a previous (currently inactive) number for this AG can be reclaimed. If the current case number is retained, the address is changed on AEICI and the case members who no longer live with the AG are deleted on AEIID.

2240.05.00 CASE TRANSFER PROCEDURES

An AG that moves to another county continues to be eligible for assistance without interruption until the new Local Office might determine otherwise. The move itself does not affect eligibility, and a reapplication or redetermination is not required.

The following procedures are to be followed in determining whether the AG continues to be eligible. In describing these procedures, County A is the county from which the AG moved and County B is the county to which the AG moved.

2240.05.05 Impact Case Intra-State Transfers (I)

When a participant moves from one county (transferring county) to another county (receiving county), the transferring county is to send the original IMPACT case file to the Local Office IMPACT Coordinator (locate on ICES Table TCRD) in the receiving county within 10 days of notification of the change.

ICES will automatically transfer the case electronically into the IMPACT Coordinator’s caseload in the receiving county when the transferring county uses PF21 on WPA1 to change the county. The IMPACT Coordinator in the receiving county will assign the case to an FCC. If the receiving county has assigned a new case number, PF21 from WPA1 will not function.

Casefile Contents- at a minimum, the casefile should contain:

All SSP's;

Documentation of all services provided so that the new FCC can make recommendations based upon a comprehensive review of the individual's participation and cooperation should there be a 24 month extension request;

Hard copies of all referrals made; and

Hard copies of all supportive services claims.

2240.10.00 RESPONSIBILITY OF INITIATING COUNTY

When a county (County A) is notified that all participating case members have established a permanent residence in another county, the caseworker must first change the address on AEICI and, if appropriate, on AEIII. Additionally, if the client provides any verification of changes to County A, the caseworker must enter the data and verification in ICES. For example, if the client notifies the caseworker of the move and also provides verification of the new shelter expenses, this information must be entered in ICES prior to transferring. AEOTR must be initiated to transfer the case.

The transfer must be initiated promptly and the caseworker is to also enter into Running Record Comments any information which may be helpful to County B. It must be done prior to AEOTR.

2240.10.05 Transferring County Responsibilities (I)

Any IMPACT activities in County A should be end-dated on screen WPAS prior to the transfer. Prior to forwarding the casefile, the transferring county should:

Approve/sign and staple the claim voucher(s) and any other required verification for any remaining unpaid supportive service(s) to the front of the casefile for payment by the receiving Local Office. The receiving county will enter the services into ICES on IMPACT screen WPPS under their county code, and

Retain a copy of the contents in the transferring Local Office for reconciliation purposes should an audit occur on a contracted service provider.

2240.15.00 RESPONSIBILITY OF RECEIVING COUNTY

When County B receives a case transferred from another county, the caseworker must contact the client and determine

what, if any, changes have occurred since the last ICES entry. Appropriate verifications must be obtained. The AG cannot be required to have another interactive interview. The caseworker must not invoke AEORE solely for the purpose of interviewing a client who has moved to County B.

2240.15.05 Receiving County Responsibilities (I)

The receiving county should review the IMPACT casefile to:

Become familiar with the client's situation, past history, and SSP;

Authorize any supportive services forwarded by the transferring office; and

Confirm continued referral status on AEIWP and WPA1.

If the participant remains mandatory for IMPACT Services, the FCC should interview the participant within 10 days of the local office receiving the ICES alert indicating the case has been transferred. The purpose of the interview is to:

Assess the participant's current situation using the IMPACT Assessment Tool.

Discuss continued participation with the participant.

Determine supportive service needs.

Review the SSP, adjust the plan to reflect changes in activities or supportive services, and address any new barriers to self-sufficiency.

Update ICES to reflect changes in the plan for employment.

NOTE: Should a participant move to an adjacent county and wish to continue participation with a contracted service provider located in the county from which the participant moved, the participant may continue until completion of the activity if approved by the receiving FCC. Because the contract is with and the referral was made by the transferring local office, this local office will be responsible for payment to the contracted service provider. The receiving local office will be responsible for payment of any supportive services associated with participation in that activity. Communication between the transferring FCC and the receiving FCC is critical. Therefore, local procedures should be established to ensure information is shared timely.

2240.20.00 TRANSMITTAL OF HARD COPY CASE RECORD

Once the case is transferred on-line, all hard copy case material for all categories of assistance is immediately sent to the new Local Office.

If the AG leaves County B to establish residence in another county before action is taken to continue assistance in County B, County B is to immediately notify County A. The three counties involved must coordinate the transfer of case materials.

2240.30.00 INTERSTATE TRANSFER CASES (C, I)

For TANF purposes, residents of Indiana who leave the state for shelter from domestic violence are considered Indiana residents unless they specifically state that they have no intention of returning to Indiana. In such instances, the FCC will have to locate the appropriate services for the individual in the state of temporary residence. When possible, this will require the FCC to work with service providers and other appropriate social service agencies and resources in the state of temporary residence.

2299.00.00 FOOTNOTES FOR CHAPTER 2200

Following are the footnotes for Chapter 2200:

(f1) 45 CFR 206.10
(f2) 42 CFR 435.916
(f3) 7 CFR 273.12(a)
(f4) 45 CFR 206.10
(f4a) 470 IAC 14-2-2
(f5) 42 CFR 431.213